2004-2005 REGULATED MEDICAL WASTE TRANSPORTER PERMIT APPLICATION

**READ THE ENTIRE APPLICATION CAREFULLY !!**

Dear Medical Waste Transporter:

Enclosed is your application to apply for/renew a permit to transport **MEDICAL WASTE** through and within the state of Rhode Island for the permit period ending June 30, 2005. Please complete and return these forms to the above address. Do not submit the application and attachments in a binder. Allow three (3) to eight (8) weeks for processing. If there are deficiencies in the application, the Department will contact you via written correspondence. You will be contacted when the application is approved, and should contact this office if you do not hear from us by the end of the 8 weeks processing period.

Renewal applications for the new fiscal year are due April 21, 2004.

## INSPECTIONS

The Department has implemented a COMPANY-CERTIFIED inspection program, thus eliminating the need for RIDEM staff inspections. Each company is required to list designated company inspectors who will perform inspections and attest to the accuracy of each inspection. A checklist for a unit inspection is attached. Please make copies of this form and submit one checklist for each unit you wish to permit. Each checklist submitted to this office must contain the signature of a designated inspector and these forms will be used as legal documents in the event of an enforcement action against the company. The Department will continue to perform random, unannounced vehicle inspections. Companies must maintain strict compliance with the requirements at all times. Units found to be deficient upon inspection are subject to administrative penalties.

Upon approval of a company's application, decals will be issued for the specific units for which a checklist and a $100 per unit fee has been submitted. These decals are NOT TRANSFERRABLE and are to be placed on the driver's side of the permitted unit.

## SPILL MANAGEMENT PLANS

All medical transporters are required to submit an emergency spill management plan in accordance with Rule 14.03 and 14.08 of the regulations. This spill management plan must be updated when any changes occur. **This contingency plan must be on each vehicle at all times.**

## FEES

A fee of $100.00 (made payable to the General Treasurer, State of Rhode Island) must be submitted to the Office of Waste Management, per the attached remittal form, at the time the application is submitted. This will be credited to the cost of the first unit. You must submit $100 for each additional unit to be permitted. No decals will be issued until payment is received.

(Note: If the units are separate, the cost to permit one tractor is $100, and the trailer is an additional $100. These are two (2) units and two (2) checklists should be submitted.)

## SEMI-ANNUAL REPORTS

As specified in section 14.14 of the *Regulations*, medical waste transporters are required to file are report semi-annually with the Department. Report specifications can be found in Appendix III of the regulations.

All additional fees and inspection checklists must be accompanied by the Check Remittal and submitted to the Office of Waste Management.

To improve the efficiency of the permitting process for both the Department and the regulated community, the Department does not require the submission of individual checklists for each vehicle for electronic filers. To be eligible to file electronically, the company must submit a *Medical Waste Transporter Electronic Submittal Form***,** along with their application **and** accompanying data in the Department's spreadsheet format **only**. The data may be sent on floppy disk or by e-mail. Contact the Office of Waste Management if you wish to file electronically.

## THIS APPLICATION MUST BE ACCOMPANIED BY THE FOLLOWING:

An application fee of one hundred dollars ($100) must be submitted to the Office of Waste Management accompanied by the enclosed remittal form. The check must be made payable to the General Treasurer, State of Rhode Island. This application fee will be credited to one unit listed on the application. An additional one hundred dollars ($100) per unit will be required for each additional unit (a tractor is one unit a trailer is another unit). All fees must be accompanied by the remittal form and **paid before** a sticker is issued.

An original (not photocopy or carbon copy) certificate of liability insurance issued in the name of the Office of Waste Management, Department of Environmental Management in the amount of at least one million dollars ($1,000,000.00).

The company must submit for review and approval, a description of the procedures to be employed by the transporter, pursuant to Rule 14.03 and 14.08 of the Regulations, in response to spills or other emergency situations that could arise during transporting operations. Specific reference must be made to:

1) Type and location of emergency equipment on vehicles.

2) The driver's emergency response instructions including:

   i) Instructions to immediately notify the RIDEM at (401) 222-1360 (daytime) or (401) 222-2284 (24-hour).

   ii) The name and phone # of an emergency spill clean-up company.

   iii) Procedures for spill containment.

   iv) Copies of the "medical waste spill and accident report" (Appendix VI) to be completed within 48 hours of spill or accident.

All correspondences should be addressed to Janice Angell at (401) 222-2797 (ext. 7517) e-mail jangell@dem.state.ri.us or Mark Dennen at (401) 222-2797 ext. 7112 e-mail mdennen@dem.state.ri.us.

**RHODE ISLAND DEPARTMENT OF ENVIRONMENTAL MANAGEMENT**
**OFFICE OF WASTE MANAGEMENT**
**235 PROMENADE STREET**
**PROVIDENCE RHODE ISLAND 02908-5767**
**(401) 222-2797**

# 2004-2005 MEDICAL WASTE TRANSPORTER PERMIT APPLICATION

**FOR YOUR CONVENIENCE SOME FIELDS HAVE BEEN PREPOPULATED WITH INFORMATION FROM YOUR EXISTING PERMIT, PLEASE NOTE ANY CORRECTIONS OR CHANGES.**

PERMIT # RI (If renewal) - _____

1. **COMPANY NAME:** _____

   MAILING ADDRESS: _____

   CITY: _____ STATE: _____ ZIP: _____

   PHONE: ( _____) _____

   LOCATION (If Different): _____

   CITY: _____ STATE: _____ Zip: _____

2. **COMPANY OWNER**: _____

3. **COMPANY EMERGENCY CONTACT**: _____

   PHONE ( ) _____

   FAX ( ) _____

4. **COMPANY REGULATORY CONTACT:** _____

   PHONE ( ) _____

   FAX ( ) _____

5. **INSURANCE COMPANY** : _____

   POLICY # _____ EXPIRATION DATE: _____

6. **IS THE APPLICATION ONLY FOR THE PURPOSE OF SELF TRANSPORTING ?** [Your status as a self transporter will be listed separately] _____

**6. IS THIS IS A RENEWAL APPLICATION? YES ____ NO _____**

If yes, have you made changes to:

| | | |
|---|---|---|
| Designated Manifest Signer List? | Yes ____ | No _____ |
| Contingency Plan? | Yes ____ | No _____ |
| Training Plan? | Yes ____ | No _____ |
| Business Concern Disclosure Statement? | Yes ____ | No _____ |

If yes to any above, you must submit the updated information with this application.

**7. STORAGE OF PERMITTED VEHICLES (complete if storage location is different than the address in item 1:**

MAILING ADDRESS (if different) : _____

CITY _____ STATE _____ ZIP _____

**8. Location of Licensed Transfer Activities or Collection Points within Rhode Island (If applicable):**

MAILING ADDRESS _____

CITY: _____ STATE : _____ ZIP _____

PHONE ( _____ ) _____

**9. List all Destination Facilities used by your company for Medical Waste generated in Rhode Island (If applicable):**

| Company | Location | Telephone # |
|---|---|---|
| | | |
| | | |
| | | |
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**10. The following personnel are authorized by _____ to sign the Medical waste Tracking Form:**

**(Company Name)**

| Name (Print or Type) | Signature* |
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**<u>* Designated employees must sign this form to signify their acceptance of this responsibility.</u>**

**Rhode Island Department of Environmental Management**
**Office of Waste Management**

## REMITTAL FORM

*** * * * ALL APPLICANTS PLEASE NOTE PROCEDURE * * * ***

The **permit application form, fee and all accompanying documents** must be submitted to:

**RI Department of Environmental Management**
**Office of Waste Management**
**235 Promenade Street**
**Providence, RI 02908-5767**

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This information must be provided to coordinate your fee with the application submitted.

Applicant's Name: _____

Mailing Address: _____

CITY: _____ STATE : _____ ZIP _____

PHONE ( ) _____

Contact Person: _____

_____ inspections x $100 per inspection = $_____(total amount submitted)

FEE PAID FOR FISCAL YEAR 7/1/20_____ TO 6/30/20_____

TYPE OF PERMIT APPLICATION:

☐ **NEW**

☐ **RENEWAL - PERMIT NO. RI_____**

☐ **PREPAID PERMIT** (For those wishing to pay for the permit in advance of having available vehicle information)

**FOR OFFICE USE ONLY:**
**Fee Amount Received: $_____**
**Date Received: _____**
**Received By: _____**
**Receipt Account: 17-18-211**
**Sent to Management Services** ☐

RHODE ISLAND DEPARTMENT OF ENVIRONMENTAL MANAGEMENT
OFFICE OF WASTE MANAGEMENT
235 PROMENADE STREET
PROVIDENCE RHODE ISLAND 02908-5767
(401) 222-2797

Medical Waste Transporter Inspection Form

**ONE CHECKLIST MUST BE SUBMITTED FOR EACH UNIT (TRACTOR OR TRAILER)**
**(Electronic Filers use form electronic version on the following page instead)**

APPLICANT: _____ Date: _____

RI Permit # RIMWTRANS: _____

Fee Submitted: Yes / No Amount: _____ Check #: _____

Vehicle Type: Box _____ Other _____ Capacity _____ Reg. #: _____ State: _____

Year/ Make: _____/_____ Last 5 digits of V.I.N.: _____

**Vehicle Requirements** 14.03(d)
Cargo Body:

_____ Fully Enclosed / Leak resistant

_____ Good and Sanitary Condition

_____ Secure when unattended

_____ Identification (name & number) in letters > 3" on both sides and back of cargo body

_____ Required Biohazard / Medical Waste signage

**Management of Spills 14.08**

_____ Management Plan on Vehicle meeting Requirements of Rule 14.08

**Spill Kit**

____ Required Absorbent Material

____ One gallon Disinfectant Sprayer

____ Appropriate Labels

____ Two (2) sets moisture resistant overalls, gloves, boots caps and tape.

____ Eye protection

____ Respiratory protection

____ Scoop, shovel, broom, bucket

____ First Aid Kit

____ Fire Extinguisher

____ Lights, flares & other appropriate safety equipment

____ Communication Device

In Accordance with Rhode Island General Law §23-19.1-18(h):

I hereby certify that I am aware that any person who knowingly makes a false, statement, representation, or certification, in any application, record, report, plan, permit, or other document filed, maintained and used for the purpose of program compliance under this chapter shall be deemed guilty of a felony.

_____ _____ _____
Signature of Designated Company Inspector Name (printed) Date

RHODE ISLAND DEPARTMENT OF ENVIRONMENTAL MANAGEMENT
OFFICE OF WASTE MANAGEMENT
235 PROMENADE STREET
PROVIDENCE RHODE ISLAND 02908-5767
(401) 222-2797

Medical Waste Transporter Inspection Form (Electronic Version)

**THIS FORM TO BE FILLED OUT ONLY FOR THOSE FILING VEHICLE DATA ELECTRONICALLY**

APPLICANT: _____ Date: _____

RI Permit # RIMWTRANS: _____

Fee Submitted: Yes / No Amount: _____ Check #: _____

Data File submitted (choose 1): By enclosed disk _____ By e-mail _____ Other: _____

Year/ Make: _____/_____ Last 5 digits of V.I.N.: _____

**Vehicle Requirements** 14.03(d)
Cargo Body:

_____ Fully Enclosed / Leak resistant

_____ Good and Sanitary Condition

_____ Secure when unattended

_____ Identification (name & number) in letters > 3" on both sides and back of cargo body

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____ Lights, flares & other appropriate safety equipment

____ Communication Device

In Accordance with Rhode Island General Law §23-19.1-18(h):

I hereby certify that I am aware that any person who knowingly makes a false, statement, representation, or certification, in any application, record, report, plan, permit, or other document filed, maintained and used for the purpose of program compliance under this chapter shall be deemed guilty of a felony.

_____ _____ _____
Signature of Designated Company Inspector Name (printed) Date

I _____, AM FAMILIAR WITH THE
(Print name)

MEDICAL WASTE TRANSPORTER PERMIT RULES AND REGULATIONS AND CERTIFY THAT ALL

ENTRIES ON THIS APPLICATION ARE TRUE AND CORRECT.

_____ _____
SIGNATURE DATE

_____
TITLE